88-1659

No. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

THEODORE KANNE and
BEATRIZ KANNE,

Petitioners,

vs.

CONNECTICUT GENERAL
LIFE INS. CO.,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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CONTENTS REPRODUCED FROM FURNISHED PRETYPED COPY.

QUESTIONS PRESENTED

1. Does the Employee Retirement Income Security Act (ERISA), 29 U.S.C. Section 1001, et seq., bar plaintiffs from securing State law remedies afforded by a State law which regulates insurance, as defined in the ERISA saving clause, 29 U.S.C. Section 1144(b)(2)(A) ("...nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance...")? [1]

2a. What are the criteria which will establish that an insurance

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1. This issue is currently before this Court on a Petition for Writ of Certiorari in at least one other case we know of: Commercial Life Ins. Co. v. Superior Court (Juliano) 47 Cal.3d 473, 764 P.2d 1059 (1988), petition filed March 15, 1989, Docket No. 88-1530. As will be seen below (Section EI infra), there will doubtless eventually be numerous other petitions to this Court presenting the same issue.

arrangement is an "employee benefit plan" subject to ERISA, under 29 U.S.C. Section 1003, where, as here, there was no formal written plan? [2]

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2. The importance of this question and the necessity for its resolution by this Court have been conceded by David L. Bacon, Esq., and Adams, Duque & Hazeltine, Esqs., counsel for the respondent herein, Connecticut General Life Ins. Co. Said counsel have recently filed a petition for Writ of Certiorari in this Court in Pacific Mutual Life Ins. Co. v. Turnbow, Docket No. 88-1546. That case presents the very same question of the criteria necessary to establish an "employee benefit plan" subject to ERISA (see Petition in Pacific Mutual Life Ins. Co. v. Turnbow, "Questions Presented," at p. i). In their Petition, Messrs. Bacon and Adams, Duque & Hazeltine state that there is "An Increasingly Significant Circuit Split," on this question "And Wide-Spread Division And Error In The Lower Courts, Which Can Only Be Resolved By This Court" (Pacific Mutual Life Petition, Point II, p. 16 [emphasis added]. See also, id. at pp. 19, 26).

It is safe to predict that there will eventually be numerous other petitions filed in this Court raising this issue, in view of the uncertainty surrounding the issue of the circumstances when an insurance arrangement constitutes an "employee

(Continued on next page)

b. Where, as here, the insureds' direct employer had not established or maintained an employee benefit plan subject to ERISA, as defined by 29 U.S.C. Section 1003(a), is such a plan established by the activities of a "group or association of employers," pursuant to 29 U.S.C. Section 1002(5), where there is no evidence that the purported employer association in question was in fact a group or association of homogeneous, related employers and no evidence that the insured's direct employer had any

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benefit plan" subject to ERISA (see Point EII, infra).

The issue of the criteria necessary to establish an "employee benefit plan" subject to ERISA is one of the issues now pending before this Court in Commonwealth v. Morash, 402 Mass. 287, 552 N.E.2d 409, cert. granted, October 3, 1988, 109 S.Ct. 53.

voice in the management of the purported employer association? [3]

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3. The petitioners herein are plaintiffs-appellees THEODORE KANNE and BEATRIZ KANNE, who were insured under a group insurance policy issued by respondent, CONNECTICUT GENERAL LIFE INSURANCE COMPANY, defendant-appellant in the Court below. The KANNES and CONNECTICUT GENERAL LIFE INSURANCE COMPANY are the only parties to these proceedings.

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No.

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October Term, 1988

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v.

CONNECTICUT GENERAL LIFE INS. CO.,
RESPONDENT

PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Theodore and Beatriz Kanne respectfully petition this Court for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

A. OPINIONS BELOW

The opinion of the District Court, filed January 23, 1985, is reported at

607 F.Supp. 899 (Appendix A, annexed hereto).

The original opinion of the Court of Appeals for the Ninth Circuit was filed on June 4, 1987, and is reported at 819 F.2d 204 (Appendix B, annexed hereto). On July 23, 1987, the Court of Appeals vacated that opinion and requested briefing on two issues: whether the insurance policy in question is a plan governed by ERISA and whether California Insurance Code Section 790.03(h)(2) is preempted by ERISA. This order is reported at 823 F.2d 284.

On October 4, 1988, the Court of Appeals issued its opinion, vacating the District Court's opinion (Appendix C, annexed hereto). This opinion is reported at 859 F.2d 96. On October 18, 1988, the Kannes filed a Petition for Rehearing. On February 2, 1989, the

Court of Appeals issued an amended opinion upon denial of rehearing (Appendix D, annexed hereto). That opinion is not yet in the official reports as of this writing.

B. JURISDICTION

The opinion of the Court of Appeals vacating the District Court's judgment for petitioners was filed on October 4, 1988. The Court of Appeals modified its opinion on denial of the Kannes' petition for rehearing, on February 2, 1989, which is the date of the judgment sought to be reviewed (Appendix D, infra). The District Court entered its order vacating the judgment on March 17, 1989. The jurisdiction of this Court is invoked under 28 U.S.C. Section 1254(1), by reason of the Court of Appeals' holding that the federal law of ERISA applies to this action, and preempts petitioners'

State law remedies.

C. STATUTES AND REGULATIONS INVOLVED IN THIS CASE

The verbatim text of the statutes and regulations involved in this case is annexed hereto as Appendix E. They are as follows: 29 U.S.C. Section 1144(b)(2)(A); 29 U.S.C. Section 1003(a); 29 U.S.C. Section 1002(5); 29 U.S.C. Section 1131; 29 CFR Section 2510.3-1(j); California Insurance Code Section 790.03(h)(2).

D. STATEMENT OF THE CASE

This action was originally filed on December 17, 1982 in the Superior Court of the State of California (Appendix A, p.2). The complaint of petitioners Theodore and Beatriz Kanne sought compensatory and punitive damages under California law against respondent Connecticut General Life Insurance Co.

(Connecticut General) and others (Appendix A, p.3). Petitioners alleged various causes of action arising out of respondent's failure to pay claims for medical benefits (ibid). On April 8, 1983, after various defendants in the case were dismissed, the case was remanded to federal court on the basis of diversity jurisdiction (28 U.S.C. Section 1332) (Appendix A, p.4).

Petitioner Theodore Kanne was an employee of Harlow Carpets (Appendix A, p.5). Respondent Connecticut General had issued a group medical insurance policy to the ABC Trust, of which Harlow Carpets was a member (ibid). On May 23, 1981, the Kannes' son, Jonathan, was born in the Netherlands two months premature (Appendix A, p.6). Because Jonathan had congestive heart failure and was cyanotic, the doctors in the Netherlands

recommended that Jonathan be treated at Moffitt Hospital in San Francisco, California (id, pp. 6-7). Pursuant to these recommendations, Jonathan was transported from the Netherlands to San Francisco by air ambulance (id, p.7).

Subsequently, petitioners incurred substantial medical bills over a period of time because of the gravity of Jonathan's condition (Appendix A, pp. 8-11). Jonathan was hospitalized after surgery for the period from October 16, 1981 to November 13, 1981 (id, p. 10). The bill for this hospitalization, in the amount of $89,840.16, was received by respondent Connecticut General on December 29, 1981, at the latest (Appendix A, at p.10). Connecticut General falsely told Mr. Kanne that it had not received the bill and used that as a pretext for not paying it (id at pp.

10-11). [4] Connecticut General paid only $9,999 on the claim in February, 1982 and $9,999 in March, 1982 (Appendix A at p.10). [5] It paid the remaining sum, totaling $69,917.44, in September and October, 1982, only after a collection agency made demand and the Kannes went to the expense of hiring an

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4. In fact, the testimony established that the bill was mailed to Connecticut General in October, 1981 (RT Vol. I, pp. 18-19, Vol. II, pp. 67-71), and that Connecticut General not only had the bill in its file, but was also repeatedly notified by a co-insurer that this bill was outstanding (RT Vol. I, pp. 63-64, Vol. II, pp. 111-115, 125, 128-9).

5. At trial, Connecticut General claimed it could not make payments of more than $9,999 at a time because its computer program could not write checks for more than four digits (RT Vol. II, p.140, lines 18-24). It also had an internal rule that it could not write more than two checks to any health care provider in any one day (RT Vol. II, p.140, line 18-p.141, line 19). Even with these artful self-imposed restrictions aimed at delaying payments, Connecticut General still could have paid the claim far more quickly than it did.

attorney (ibid).

The District Court found that "Connecticut General neither has justified the delay in these payments nor has provided any rationalization for its failure to investigate in a timely fashion the status of the $69,141.44 sum. Connecticut General knew or should have known that the sum had not been paid at least as early as December 29, 1981, when it received the balance forward indication on the $89,840.16 bill." (Appendix A, at p. 21) (emphasis added). [6]

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6. The Department of Labor regulations provide that an insurance company administering an ERISA plan is permitted to delay any decision as to whether to pay a claim for up to 300 days, by availing itself of extensions of time permitted by the regulations. 29 CFR Section 2560.503-1(e)(1)(3); Section 2560.503-1(h). Even if the 300-day provision is violated, the insurer is not

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The Kannes suffered excruciating emotional turmoil because of Connecticut General's failure to pay these bills. The Kannes feared they would not be able to secure for Jonathan the medical attention necessary for his survival (RT Vol. I, pp. 22-24, 71-76, Vol. II, p.76). Because Connecticut General didn't pay

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subject to any penalties because the only result of failure to comply is that the claim is deemed denied. See 29 CFR Section 2560.503-1(h)(4); Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 144, 105 S.Ct. 2380, 3091 (1985).

The result is that the inordinate delays in payment allowed by ERISA force health care providers to, in effect, provide interest-free loans to insurance companies. Thus, the effect of broad ERISA preemption on health care providers could well be catastrophic.

Considerations such as these impelled the California Medical Association to file an Amicus Curiae Brief in the California Supreme Court in Goodrich v. General Telephone Co. of California, S002951, and in Commercial Life Ins. Co. v. Superior Court, supra, FN 1, supra, urging that ERISA should not preempt state laws regulating insurance.

Jonathan's physicians, said physicians demanded that the Kannes pay cash for all future visits (RT Vol. I, p.24, lines 10-20, pp. 72, 76). Mrs. Kanne was therefore compelled to sneak out of the doctors' offices after visits because the Kannes couldn't pay the bills (RT Vol. I, p.24, lines 21-24). [7]

Connecticut General's delays were not caused by any dispute over whether the claims were justly due. The only claim that Connecticut General disputed was the claim for payment of the air ambulance. Connecticut General rejected this claim, assigning different professed reasons at different times (Appendix A at

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7. Mr. Hanna, the manager of Connecticut General's Los Angeles Claims Center (RT Vol. IV, p.9), testified that taking 11 months to pay a claim that was clearly due would not violate Connecticut General's standards (RT Vol. IV, p.16, line 20 to p.17, line 2).

pp. 17-18). [8]

United States District Judge Edward Rafeedie, sitting without a jury, found that Connecticut General had breached the common law duty of good faith and fair dealing (Appendix A, pp. 22-27) and also violated California Insurance Code

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8. Although Connecticut General claimed in this litigation that it was acting as an ERISA "claims review fiduciary" (see, e.g., Connecticut General's reply brief to the Court of Appeals, served January 30, 1986, at pp. 23, 36, 38), it never produced any evidence that it (or anyone else) ever complied with ERISA's claims review procedures, which required Connecticut General to notify the Kannes of their rights to review of its decision denying this claim. See, e.g., 29 CFR Section 2560.503-1(f)(g).

Thus, while Connecticut General has insisted throughout this litigation that this matter is governed by ERISA, it ignored ERISA requirements when compliance with these requirements was inconvenient or potentially costly to it, and none of the entities involved in this case (i.e., Connecticut General, Harlow Carpets or ABC Trust) has ever shown that they complied with any of ERISA's requirements.

Section 790.03(h)(2), which prohibits the failure to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies (Appendix A, pp. 32-33). He found that Connecticut General's behavior caused the Kannes emotional distress damages in the sum of $250,000 (Appendix A, pp. 37-38), and that Connecticut General's behavior was so outrageous that an award of $500,000 exemplary damages was appropriate as a penalty and deterrent (Appenix A, pp. 37-38).

The District Court also held that the insurance covered the air ambulance expenses (Appendix A, pp. 16-20). Another insurer, Metropolitan Life Ins. Co., had paid its share of these expenses (id, p.7), leaving a balance of $2,234.88 that was payable by Connecticut General (id at p.20).

The District Court also considered Connecticut General's contention that ERISA preempted the Kannes' cause of action and stated that the insurance arrangement was an ERISA plan (Appendix A at p.12). The District Court did not state its reasons for this conclusion, which was immaterial to the decision, since the District Court also concluded that ERISA did not preempt the Kannes' causes of action (id at pp. 12-14). [9]

Respondent appealed the District Court's judgment to the Ninth Circuit

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9. At about the time of the District Court's decision, there were a number of cases holding that ERISA preemption did not apply to actions for insurance bad faith, because of the saving clause, 29 U.S.C. Section 1144(b)(2)(A). See, e.g.: Presti v. Connecticut General Life Ins. Co., 605 F.Supp. 163 (N.D. Cal. 1985); McLaughlin v. Connecticut General Life Ins. Co., 565 F.Supp. 434 (N.D. Cal. 1983); Eversole v. Metropolitan Life Ins. Co., 500 F.Supp. 1162 (C.D. Cal. 1980).

Court of Appeals. The appeal was first argued and submitted on April 7, 1986 (Appendix D at p.75). On July 2, 1986, the appeal was withdrawn from submission, pending this Court's decision in Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549 (1987) (Appendix D at pp. 76, 82). On June 4, 1987, after Pilot Life was decided, the Court of Appeals resubmitted the case and reversed the District Court's conclusion that the Kannes' claims were not preempted (Appendix B, pp. 44-52, Appendix D, pp. 83-84). On July 23, 1987, the Court of Appeals granted the Kannes' petition for rehearing and directed the parties to brief two issues: whether the Kannes' cause of action under California Insurance Code Section 790.03(h)(2) is preempted by ERISA and whether the insurance policy in question is a plan

governed by ERISA. 823 F.2d 284, Appendix D, pp. 77 and 84. On November 23, 1987, the Court of Appeals heard oral argument on these issues (Appendix D at p.76).

On October 4, 1988, the Court of Appeals filed its opinion, reversing the District Court's decision (Appendix C, pp. 53-74). The Kannes filed another petition for rehearing on October 18, 1988. On February 2, 1989, the Court of Appeals modified its opinion and denied the petition for rehearing (Appendix D, at pp. 75, et seq.).

As the opinion of the Court of Appeals demonstrates, the disposition of the issue of whether ERISA preempts petitioners' State law remedies under the State statute, California Insurance Code Section 790.03(h), depends on the interpretation of this Court's decision

in Pilot Life Ins. Co. v. Dedeaux, supra (see Appendix D at pp. 91-96). The Kannes contended that Pilot Life was inapplicable because that case held only that ERISA preempted common law causes of action which were not state laws regulating insurance, and hence did not come within the ERISA savings clause. The Kannes contended that their cause of action for breach of California Insurance Code Section 790.03(h)(2) is exempt from ERISA by the savings clause, since Section 790.03(h)(2) is a law which regulates insurance (Appendix D at p.93).

The Court of Appeals held that it was unnecessary to determine that issue. The Court said:

> "We can assume, without deciding, that section 790.03(h) is a law regulating insurance under the savings clause." (Appendix D at p. 93) (emphasis added)

The Court of Appeals held that ERISA preempted petitioners' cause of action even if that cause of action was based on a State law regulating insurance within the meaning of the savings clause (Appendix D at pp. 93-96). The Court of Appeals interpreted the second part of this Court's decision in Pilot Life (481 U.S. at pp. 51-57, 107 S.Ct. at pp. 1555-8) to mean that ERISA civil enforcement provisions are exclusive even where plaintiffs are proceeding under a State law regulating insurance (Appendix D at pp. 93-96).

The Court of Appeals also held that the insurance arrangement was a plan subject to ERISA (Appendix D at pp. 84-91). The Court recognized that under Department of Labor regulation 29 CFR Section 2510.3-1(j) (1987) a group insurance program is excluded from ERISA

if it contains the four criteria described therein (Appendix D, pp. 87-88). The Court concluded that the evidence failed to establish that Mr. Kanne's actual employer, Harlow Carpets, had conducted any activities which would take the insurance arrangement outside the four criteria of the regulation (Appendix D at pp. 88-89). However, the Court held that Associated Builders & Contractors (ABC), which purchased the group insurance from Connecticut General, could be considered an "ERISA employer," under 29 U.S.C. Section 1002(5) (Appendix D at pp. 89-90), which provides that an "employer" includes "a group or association of employers acting for an employer in such capacity." [10]

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10. As the Court knows, in order for a plan to be governed by ERISA, it must be established or maintained by any

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The Court of Appeals held that ABC was an employer group or association within the meaning of 29 U.S.C. Section 1002(5), and that the arrangement was an ERISA plan because "ABC does not merely advertise the group insurance, but rather, as the administrator of the plan, 'endorses' it," thereby establishing the non-existence of one of the four criteria set forth in 29 CFR Section 2510.3-1(j) for excluding a plan from ERISA (the third criterion) (Appendix D at p.90). The Court concluded that if any of the four criteria are absent, an ERISA plan is established. See Appendix D at pp. 88, 89.

However, the opinion acknowledges

"employer" (unless it is established or maintained by an employee organization, which is not claimed here). 29 U.S.C. Section 1003(a), set forth in Appendix E, infra.

that at the trial "the parties did not contest the issue of whether the ABC Trust was an ERISA plan" (Appendix D, p.86), and this issue was never litigated. Hence, the opinion's assumption that ABC was a bona fide employer group within the meaning of 29 U.S.C. Section 1002(5) is not supported by any evidence. See Section EII, infra. [11]

Finally, the Court held that even the Kannes' claim for reimbursement of the air ambulance costs was preempted (Appendix D, pp. 96-97). The Court said that California's common law of contracts is not a law that regulates insurance (id

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11. These matters were pointed out in petitioners' petition for rehearing to the Court of Appeals filed October 18, 1988.

The Court of Appeals' modification of the opinion on denial of the rehearing (Appendix D) did not further discuss these matters.

at p. 97). The Court did not discuss any reason that this claim could not be recovered under ERISA (see 29 U.S.C. Section 1132[a][1][B]). The Court of Appeals apparently assumed that the "arbitrary and capricious" standard governed claims brought under ERISA, as contended by Connecticut General (see, e.g., Connecticut General's reply brief filed in the Court of Appeals, served January 30, 1986, at p. 36).

E. REASONS THE WRIT SHOULD BE GRANTED

I. THE ISSUE OF WHETHER ERISA PREEMPTS STATE LAW REMEDIES PROVIDED BY A STATE LAW REGULATING INSURANCE IS AN ISSUE OF WIDESPREAD IMPORTANCE; IT IS URGENT THAT THIS COURT RESOLVE THIS ISSUE. [12]

The first question presented clearly comes within the criteria of Rule 17.1. It is of tremendous importance and impacts on the rights of literally millions of citizens of this country who have employee group health and medical insurance policies and seek State law

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12. As noted above (Footnote 1, supra), the identical issue is presented in the Petition for Writ of Certiorari in the Commercial Life case, supra. We have read that petition and adopt the arguments contained therein by reference. We will hereinbelow address ourselves to additional reasons that the instant issue merits the granting of the Kannes' petition.

remedies when the insurers' failure to honor these policies causes serious hardship to ill and disabled policyholders.

Indeed, the importance of this issue has been conceded by one of respondent's counsel, David L. Bacon, Esq., who has said that "[i]t's hard to overstate the importance" of the Court of Appeals' decision in the instant case (Los Angeles Daily Journal, October 5, 1988, p.1., column 4) and "[t]here are hundreds of pending suits in California which involve this very issue and hundreds and [sic] millions of dollars [are] involved." (Wall Street Journal, October 5, 1988, p.A-24, column 4).

In California alone, there are scores, if not hundreds, of cases pending whose resolution is determined by the issue of whether a citizen of a State may

seek State law remedies for redress of violations of State laws regulating insurance. In Commercial Life Ins. Co. v. Superior Court, supra, the California Supreme Court, in holding that actions for breach of State laws regulating insurance are preempted by ERISA, relied extensively on the decision of the Court of Appeals in the present Kanne case. See 47 Cal. 3d at pp. 482-484, 764 P.2d at pp. 1064-1066. [13] There are

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13. The California Supreme Court took for review at least five other cases presenting the same issue: Goodrich v. Gen. Tel. Co., supra, No. S002951, DeFiori v. Bankers Life, No. S003448, Pilot Life v. Superior Court, No. S003351, Blue Cross of Cal. v. Superior Court, No. S004471 and General Tire & Rubber Co. v. Superior Court, No. LA32272. It retransferred these cases to the California Courts of Appeal on February 23, 1989 for reconsideration in the light of the Commercial Life decision. Commercial Life and these five other cases which had already reached the California Supreme Court are just the tip of the iceberg.

countless other cases pending in the Ninth Circuit and U.S. District Courts of California and in the California State Courts which present the very same issue. [14]

Although the California Supreme Court has now judicially abolished the private right of action under California Insurance Code Section 790.03(h), the Court made it clear that the Legislature of the State of California has the power to reinstate this right of action.

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14. The instant Kanne case is the leading federal case on the subject, and its importance is underscored by the numerous Amicus Curiae Briefs filed in the Court of Appeals. Amicus Curiae included the United States Government in support of Connecticut General and the Attorney General of the State of California in support of the Kannes. The American Council of Life Insurance, the Health Insurance Association of America and the Association of California Life Insurance Companies also filed Amicus Curiae Briefs in support of Connecticut General. Other "numerous amici" supported the Kannes (Appendix D at pp. 78, 93).

Moradi-Shalal v. Fireman's Fund Ins. Cos., 46 Cal.3d 287, 305, 758 P.2d 58, 69 (1988). Moreover, the Moradi-Shalal decision applies prospectively only, and does not affect the large number of pending cases asserting causes of action under California Insurance Code Section 790.03(h). See 46 Cal.3d at p.305, 758 P.2d at p. 69.

Nor is the reach of the present issue confined to California. Numerous other states have laws which seek to deter unfair insurance practices by assessing various penalties. See, e.g.: Van Dyke v. St. Paul Fire & Marine Ins. Co., 448 N.E.2d 357 (Mass. 1983) (cause of action allowed for breach of Massachusetts' Insurance Unfair Claims Practices Act); Griswold v. Union Labor Life Ins. Co., 442 At1.2d 920 (Conn. 1982) and Mead v. Burns, 509 At1.2d 11

(Conn. 1986) (cause of action allowed for breach of Connecticut's Unfair Trade Practices Act); Sparks v. Republic Nat. Life Ins. Co., 647 P.2d 1127 (Ariz. 1982), cert. den., 459 U.S. 1070, 103 S.Ct. 490 (1982) (to the same effect under Ariz. Rev. Stats Section 20-443); Jenkins v. J.C. Penney Cas. Ins. Co., 280 S.E. 2d 252 (W.Va. 1981) (to the same effect under West Virginia statute); Klaudt v. Flink, 658 P.2d 1065 (Mont. 1983) (to the same effect under Montana statute); Mo. Rev. Stat. Section 375.296 (allowing extracontractual damages and attorneys fees against insurance companies for vexatious refusal to pay); Tex. Ins. Code Ann. Art. 3.62 (same); La. Rev. Stats 22:657 (providing for penalties for failure to promptly pay claims arising out of health and accident contracts).

The foregoing statutes, and similar statutes in other states, will be rendered a nullity under the Kanne Court's interpretation of this Court's decision in Pilot Life, supra. The Kanne Court's interpretation of Pilot Life in effect attributes to this Court's opinion in Pilot Life a statutory interpretation which ignores the plain words of the statute. The Kanne Court's interpretation is that the savings clause does not apply to ERISA's enforcement provisions. This is plainly incorrect.

The savings clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance..." 29 U.S.C. Section 1144(b)(2)(A) (emphasis added). The "subchapter" referred to is Subchapter I of ERISA, entitled "Protection of

Employee Benefit Rights." The savings clause is in Part 5 of Subchapter I. The ERISA enforcement provisions are also in Part 5 of Subchapter I. See 29 U.S.C. Section 1132. Hence, the statute clearly provides that ERISA's enforcement provisions do not apply to State laws regulating insurance. To interpret Pilot Life as holding otherwise would impute to this Court an intention to ignore the plain words of the statute--an intention which cannot be imputed to this Court.

It is particularly inappropriate to impute such an intention to this Court from statements in the Pilot Life decision because the issue was not before this Court in Pilot Life. Pilot Life did not involve a State law regulating

insurance. [15]

We believe that the more rational interpretation of the second half of Pilot Life--and the interpretation consistent with the statutory language--is that the discussion therein merely was

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15. Two other Court of Appeals decisions have interpreted Pilot Life in a fashion similar to the Ninth Circuit's interpretation. See, e.g.: In Re: Life Ins. Co. of North America, 857 F.2d 1190 (8th Cir. 1988) (the Court held that ERISA preempts Mo. Rev. Stat. Section 375.420, which provides a penalty for vexatious refusal to pay insurance benefits. The Court relied on the second portion of the Pilot Life opinion, which it construed as holding that "no state law purporting to supply additional remedies will escape the preemptive effect of Section 1144(a) as laws 'which regulate insurance' under Section 1144(b)(2)(A)" [857 Fed. 2d at p.1194]); Anschultz v. Connecticut General Life Ins. Co., 850 F.2d 1467 (11th Cir. 1988) (holding that under Pilot Life, ERISA preempts the Florida Insurance Unfair Practices Act, Florida Stat. Section 624.155. The Court, relying on the second portion of Pilot Life, held: "where otherwise applicable, ERISA preempts all state law." [850 F.2d at p.1469] [emphasis in original]).

intended to set out another element to consider in determining whether a State law regulates insurance so as to come within the saving clause. In discussing the criteria to be utilized in determining whether the saving clause applies, this Court in Pilot Life said that several considerations guided it. 481 U.S. at p.48, 107 S.Ct. at p. 1553. First, this Court was guided by a "common-sense view of the language of the saving clause itself" (ibid). Then, it applied the three criteria set forth in Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129, 102 S.Ct. 3002, 3009 (1982) (481 U.S. at pp. 48-51, 107 S.Ct. at pp. 1553-4). Finally, in the portion of Pilot Life relied on by the Court of Appeals in the instant case, this Court considered the role of ERISA in promoting uniformity of enforcement for actions by

ERISA-plan participants and beneficiaries (481 U.S. at pp. 51-57, 107 S.Ct. at pp. 1555-1558).

We submit that this last criterion constitutes a criterion this Court considered in determining the scope of the saving clause and it alone cannot take a state law regulating insurance outside the ambit of the saving clause. Otherwise, it would nullify the saving clause completely, and would make superfluous this Court's previous discussion in the Pilot Life opinion as to whether the State law in question regulated insurance and satisfied the Union Labor Life requirements.

Thus, the opinion in Pilot Life concludes with the statement that the "state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by

Section 514(b)(2)(a) and therefore is pre-empted by Section 514(a)." (481 U.S. at p. 57, 107 S.Ct. at p.1558) (emphasis added). We interpret this to mean that the suit was pre-empted because the law involved was not a State law regulating insurance within the saving clause. It does not mean that suits based on State laws which do regulate insurance and are hence within the saving clause are also subject to pre-emption. If this Court intended to hold that ERISA's enforcement provisions preempt all State laws regardless of whether or not they regulate insurance, it would have been wholly unnecessary for this Court to extensively discuss all of the reasons that the Mississippi common law rules involved in Pilot Life did not constitute a state law regulating insurance.

This conclusion is supported by this

Court's decision in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380 (1985), where this Court held that there is a presumption against pre-emption of areas of "traditional state regulation" (471 U.S. at p.740, 105 S.Ct. at p.2389) and that "we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope." (471 U.S. at p.741, 105 S.Ct. at p.2390). This Court rejected the contention that "Congress intended [a] narrow reading of the saving clause." (471 U.S. at pp. 745-746, 105 S.Ct. at p. 2392. See also 471 U.S. at pp. 746-747, 105 S.Ct. at p.2393). This Court stated that the saving clause is "broad on its face" (471 U.S. at p. 746, FN 24, 105 S.Ct. at p.2393, FN 24). These statements establish that the saving clause may not be nullified by refusing

to apply it to a situation that comes squarely within its terms.

The interpretation of the Court of Appeals in the instant case would mean that this Court did a complete about face only two years after Metropolitan Life was decided. Pilot Life contains nothing to indicate that this Court intended to effect such a sweeping reversal of the holding in Metropolitan Life.

We respectfully submit that the District Court in Graves v. Blue Cross of California, 688 F.Supp. 1405 (N.D. Cal. 1988) correctly interpreted Pilot Life. Therein, the Court rejected the interpretation that the second half of Pilot Life limited actions under State laws regulating insurance to ERISA remedies. The Court said:

> "...such a holding would conflict with both the language of ERISA itself and the Supreme

Court's pronouncements in Metropolitan Life. . .Since ERISA's civil enforcement provisions are contained in the same subchapter as the saving clause, see 29 U.S.C. Section 1132, the plain language of the statute precludes a ruling that state laws falling within the boundaries of the saving clause are nevertheless preempted if they interfere with the policies underlying the exclusive civil enforcement scheme. In effect, such a holding would rewrite the saving clause..." (688 F.Supp. at pp. 1412-1413) (emphasis added).

The District Court then noted the language of Metropolitan Ins. Co. v. Massachusetts, supra, and said:

"In this Court's view, the only way to square Pilot Life with Metropolitan Life and the plain language of ERISA is to read the Pilot Life exclusivity analysis as merely bolstering the Court's apparent conclusion that the Mississippi bad faith law was not insurance regulation within the meaning of the saving clause. In other words, the insurance regulation and exclusive remedy discussion in Pilot Life are not independent, alternative

> holdings, but interdependent considerations supporting the Court's conclusion that the saving clause does not apply." (688 F.Supp. at p.1413) (emphasis added)

In Commercial Life, supra, the dissenting opinion of Justice Mosk (joined in by Justice Broussard) points out that under the statute it is plain "that Section 790.03(h) is saved from preemption by the express terms of ERISA: the provision clearly 'regulates insurance' [citation]. As I read their opinion, the majority do not seriously dispute that section 790.03(h) comes within ERISA's saving clause--nor could they [citation]. * * * ERISA does not preempt Section 790.03(h), but expressly saves the provision as a law 'regulat[ing] insurance.' Further, the civil enforcement scheme of the federal statute does not displace the civil

enforcement scheme of the state act: the former concerns the rights of employees under covered plans, the latter the duties of insurers under state laws." (47 Cal. 3d at pp. 488-489, 764 P.2d at pp. 1068-1069).

Justice Mosk then said:

> "There is a growing and ominous trend toward federal preemption of issues that belong within the sphere of control by the individual states. And these inroads into traditional federalism are taking place despite their inconsistency with pious rhetoric emanating from Washington about returning government to the people at state and local levels." (47 Cal. 3d at p. 490, 764 P.2d at p.1069) (emphasis added).

We respectfully submit that these comments are particularly appropriate in light of the fact that the insurance industry--with all the vast and able legal resources at its command--has been unable to cite in support of its position

one single expression from Congress in all of the writings on ERISA's legislative history. Nothing in that history shows that Congress intended to place sick and disabled beneficiaries of employee group insurance plans at the mercy of their insurers. To the contrary, the saving clause constitutes a plain expression of Congress' intent to leave to the States the traditional State law regulation of the duties of insurers to the States' citizens, as Justice Mosk pointed out. See also: Petition for Writ of Certiorari in Commercial Life, supra, which sets forth other authorities regarding the intent of Congress.

We respectfully submit that these serious questions concerning interpretation of Pilot Life urgently require this Court to grant the instant petition and definitively resolve the

question of whether or not the States are powerless to enact or enforce legislation designed to deter insurance companies from inflicting on a State's citizens anguish and hardship such as that suffered by the Kannes at bar. We respectfully submit that this issue is a vitally important question of federal law which has not been, but should be, settled by this Court (Rule 17.1(c)), regardless of whether we are right or wrong with respect to the ultimate result.

II. THE ISSUE OF THE ELEMENTS NECESSARY TO ESTABLISH THAT AN INSURANCE ARRANGEMENT IS AN "EMPLOYEE BENEFIT PLAN" SUBJECT TO ERISA IS AN ISSUE OF WIDE-SPREAD IMPORTANCE WHICH HAS NEVER BEEN RULED ON BY THIS COURT.

The issue of the elements necessary to establish that a group insurance policy is an "employee benefit plan" subject to ERISA, pursuant to 29 U.S.C. Section 1003(a), is also appropriate for review, under the criteria of both Rule 17.1(a) and (c). As will be seen below, the instant decision is in conflict with other Court of Appeals decisions on this issue. It is a vital issue which affects every insurance arrangement made in an employment setting. It affects the rights of citizens of States to pursue State law remedies in cases where an employer arranges for an insurance policy covering its employees, but there is no written employee benefit plan and no evidence that the employer had any intention whatever to establish an employee benefit plan subject to ERISA or made any attempt to comply with the

various ERISA regulations governing such plans. Such regulations include numerous onerous reporting and record keeping requirements. See, e.g. 29 U.S.C. Sections 1021-1029. An employer who willfully violates any of these provisions is guilty of a criminal act, subjecting that employer to fine and imprisonment. 29 U.S.C. Section 1131. See Taggart Corp. v. Life & Health Benefits Admin., 617 F.2d 1208, 1211 (5th Cir. 1980), cert. den. sub. nom., Taggart Corp. v. Efros, 450 U.S. 1030, 101 S.Ct. 1739 (1981).

We respectfully submit that employers, who are subject to criminal prosecution, and employees, who are threatened with loss of valuable rights under State law, should be clearly and definitively advised by this Court of the circumstances when an insurance

arrangement constitutes an "employee benefit plan" subject to ERISA.

This Court has never spoken on this issue. A leading case from this Court makes it clear that the provisions of ERISA do not apply unless there is a plan or program. Fort Halifax Packing Co. v. Coyne, ____ U.S. ____, 107 S.Ct. 2211 (1987). It does not address the issue of the elements necessary to establish such a plan or program.

The present opinion of the Court of Appeals graphically demonstrates the confusion and conflict among the Courts on this issue. The Court of Appeals' finding that an unwritten "employee benefit plan" subject to ERISA existed in the present case was based on at least two propositions that are the subject of conflict among the authorities:

(1) The proposition that the

nonexistence or absence of any of the four criteria set forth in Department of Labor regulation 29 CFR Section 2510.3-1(j) is sufficient to subject an insurance arrangement to ERISA (see Section D, supra, Appendix D at pp. 88, 89, 90).

(2) The proposition that the acts of an employer association, as defined in 29 U.S.C. Section 1002(5), is sufficient to subject an insurance arrangement to ERISA, even when there is no evidence that the direct employer played any part in the management of the employer association and no evidence that the employer association consisted of homogeneous, related employers (Section D, supra. Appendix D at pp. 86, 89-90).

In the present case, the Court of Appeals relied on these two propositions to strip the Kannes of their rights under

well-established State law--and of the fruits of this protracted and expensive litigation.

The questionable nature of the first proposition is established by holdings that the nonexistence of one of the four criteria set forth in the Department of Labor regulation does not establish that an insurance arrangement is subect to ERISA. Thus, for example, in Rizzi v. Blue Cross of So. Cal, 206 Cal. App. 3d 380, 253 Cal. Rptr. 541 (1988) the Court analyzed the authorities and pointed out that some authorities have held that there is no ERISA plan "where the employer 'endorsed' the policy sold by an insurance trust, but the employer had no control of the trust operation, contributed no funds on behalf of the employees, and the insurance brokers sold the policies directly to individual

employees who paid the entire premiums. [citations]" 206 Cal. App. 3d at p.386, 253 Cal. Rptr. at p.545 (emphasis added). At bar, on the other hand, the alleged presence of endorsement, which established the non-existence of the third criterion in the Department of Labor regulation, was held to be sufficient by itself to establish an unwritten ERISA plan. See Appendix D at pp. 88, 89, 90. See also: Sayble v. Blue Cross of So. Cal., ___ Cal. App. 3d ___, ___ Cal. Rptr. ___, filed March 20, 1989 (reported in the Los Angeles Daily Journal Daily Appellate Reports for March 22, 1989 at p. 3587) (the Court held that payment of premiums, which established the non-existence of the first criterion in the Department of Labor regulation, was not sufficient to establish an employee benefit plan where, as at bar,

there was no evidence of any other employer involvement).

Moreover, in the present case the Court of Appeals did not even find that Mr. Kanne's direct employer's involvement established the absence of any of the four Department of Labor criteria. The Court of Appeals found only that the acts of ABC, an alleged employer group, constituted "endorsement," establishing the absence of the third criterion (Appendix D, pp. 88-90).

However, in order to be an "ERISA employer" under 29 U.S.C. Section 1002(5), an alleged employer group or association must be "a group or association of employers acting for an employer in such capacity." It has been held that an employer association is not an "ERISA employer" under this provision, unless the evidence establishes that the

individual employer played a part in management of the employer association. If the employer association fails to show what role the individual employers played in its management, it is not covered by ERISA. See, e.g., Matthew 25 Ministries, Inc., v. Corcoran, 771 F.2d 21 (2d Cir. 1985); Donovan v. Dillingham, 688 F.2d 1367, 1373, FN 11 (11th Cir. 1982). See also Hamberlin v. VIP Ins. Trust, 434 F.Supp. 1196, 1198 (D. Ariz. 1977) (for an employer group to be an ERISA plan, the employers must have a voice in its management); Baucom v. Pilot Life Ins. Co., 674 F.Supp. 1175, 1181 (M.D.N.C. 1987) (same); Insurance & Prepaid Benefits Trusts v. Marshall, 90 FRD 703 (C.D. Cal. 1981) (an employer group can qualify as an ERISA plan only when such group involves an association of employers, the employers participate in

the benefit committee and that committee makes final decisions). See also: Rizzi, supra.

Moreover, where an employer group consists of "heterogeneous, unrelated employers," ERISA is inapplicable. Credit Managers Ass'n v. Kennesaw Life & Acc. Ins., 809 F.2d 617, 625 (9th Cir. 1987). In the Rizzi case, supra, the California Court of Appeal specifically questioned the instant Kanne decision because of this rule (206 Cal. App. 3d at p.386, FN 4, 253 Cal. Rptr. at p.544, FN 4).

Thus, the Court of Appeals' holding in the instant case is directly contrary to all of the above authorities, since there was no evidence that Harlow Carpets (or, for that matter, any other employer) played any part in the management of ABC, the purported "ERISA employer," and no

evidence that ABC was a group of homogeneous, related employers.

Another conflict among the authorities is presented by the question of whether employer intent is necessary to establish an unwritten employee benefit plan subject to ERISA.

In Wayne Chemical v. Columbus Agency Service Corp., 567 F.2d 692 (7th Cir. 1977), the Court held that an employee benefit plan governed by ERISA is not established when the employer applies for insurance and pays premiums "without any knowledge that the plan exists. Establishing, maintaining or participating in a plan requires an intent, ..." (567 F.2d at p.699) (emphasis added) Similarly, the opinion of the Court of Appeals in the present case also indicates that an intent to form an ERISA plan is necessary, since it

found such intent, although only on the part of ABC (Appendix D at p.90). On the other hand, Donovan v. Dillingham, supra, indicates that intent is unnecessary, since it sets forth different criteria for determining whether a plan is governed by ERISA (688 F.2d at p. 1373). [16] Rizzi, supra, specifically raises the question of "whether a test based on an employer's subjective intent is appropriate." (206 Cal. App. 3d at p. 387, FN 7, 253 Cal. Rptr. at p.545, FN 7).

The Courts of Appeal are also in conflict on the subject of whether the "bare purchases of health insurance" may constitute a "plan" subject to ERISA.

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16. The Donovan test is "whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits" (688 F.2d at p. 1373).

Taggart Corp. v. Life & Health Benefits Admin., supra, 617 F.2d 1208, 1211, held that there is no ERISA plan under these circumstances. Donovan v. Dillingham, supra, holds that "bare purchases of health insurance" is evidence of an employee benefit plan governed by ERISA and the issue is one of fact to be decided on a case by case basis (688 F.2d at p.1373). Donovan specifically disapproves the holding of Taggart Corp., supra, on this subject. (688 F.2d at p. 1375).

In Rizzi v. Blue Cross of So. Cal., supra, the California Court of Appeal noted the confusion and inconsistency among the authorities (206 Cal. App. 3d at pp. 384-388, 253 Cal. Rptr. at pp. 543-546), stating that the various "analytical approaches" the Courts have considered "do not always coincide" (206

Cal.App.3d at p. 389, 253 Cal.Rptr. at p. 547).

Indeed, as noted above (FN 2, supra), counsel for respondent have themselves advised this Court that there is "An Increasingly Significant Circuit Split And Wide-Spread Division And Error In The Lower Courts" on this subject (Petition in Pacific Mutual Life Ins Co. v. Turnbow, supra, p. 16); a "sharp Circuit conflict" on this subject (id. at p. 18); and "increasing division and error in the lower courts on ERISA's most basic issues of coverage and preemption, all stemming from an irreconcilable Circuit conflict." (id. at p. 19).

It is therefore clear that the certainty so urgently needed on this subject is utterly lacking, and it is vital that this Court issue a definitive pronouncement of the criteria that

determine what constitutes an employee benefit plan governed by ERISA, under 29 U.S.C. Section 1003(a). We respectfully suggest that this Court should adopt criteria which may be easily understood and applied.

We respectfully submit that it would be error to permit vague, ambiguous and obscure criteria to determine this question, and particularly because of the criminal sanctions which may be imposed upon employers for failure to comply with ERISA requirements, under 29 U.S.C. Section 1131. It is elementary that a criminal statute must be plain and unambiguous. Under current authorities, there is no way of knowing with certainty when ERISA is applicable and when the duty of compliance with ERISA regulations arises.

We therefore respectfully submit

that it is urgently necessary that the state and federal courts throughout this country receive concrete guidance from this Court on this subject. Otherwise, confusion and uncertainty will proliferate and will create intolerable chaos in the state and federal court systems. [17]

Conclusion

This Court's decision in Pilot Life, supra, urgently requires clarification in order that the States may know whether or

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17. Prior to this Court's decision in Pilot Life, most courts had held that ERISA did not preempt common law causes of action for bad faith. See, e.g., cases cited at FN 9, supra. Under Pilot Life there are a large number of common law bad faith cases throughout the country that would be preempted by ERISA, if it applies, and the issue of whether it applies, which was largely academic before Pilot Life, has now become pivotal. See, e.g., Appendix D at pp. 86-87.

not they have the power to enact laws regulating insurance which will effectively deter predatory insurance practices such as those demonstrated by the record at bar. It was never the intention of Congress to handcuff the States' ability to protect their citizens from the hardships which may result from such practices. Nor did Congress intend to compel health care providers, such as hospitals--whose costs and finances are already a grave national problem--to, in effect, make interest-free loans to insurance companies (see FN 6, supra).

It is also urgently necessary that the State and Federal Courts be afforded guidance with respect to when the federal law embodied in ERISA applies to medical and disability insurance arrangements that are not the subject of any written employee benefit plan. The consequences

of the present state of confusion and uncertainty are most grave. All sides to this controversy agree that an authoritative pronouncement from this Court is necessary to prevent the further spread of this deeply troubling confusion and uncertainty.

Respectfully submitted,

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